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AUTHOR Reiss, David; And Others
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ABSTRACT

This is a comprehensive report of a study of the mechanisms by which the family regulates its interaction with the immediate social environment. Subjects were four multiple family groups, each composed of six or more families, meeting in both hospital and home settings. In each family, at least one member was either an alcoholic or an adolescent with behavioral problems. The authors include descriptions of each group and its dominant characteristics. Data is based primarily on observations of group interaction, attendance patterns and sociometric questionnaires. A crucial question is whether the multiple family group duplicates, in any meaningful way, the social process of everyday social settings. The results suggest that "community-like" processes do develop spontaneously in multiple family groups. These include the differentiation of these groups into subgroups (often peer groups), social stratification (particularly along dimensions of power, prestige and conspicuousness) and phenomena related to the family's first entry into and final departure from the group. Findings also indicate the potential usefulness of the multiple family group as an observational setting as well as modifications still required of the model. (Author/DOW)

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THE MULTIPLE FAMILY GROUP AS A SMALL SOCIETY:

Fitting Theory and Method

David Reiss, M.D., Peter Steinglass, M.D. and Ronald Costell, M.D.

Center for Family Research
Department of Psychiatry and Behavioral Sciences
George Washington University School of Medicine

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BACKGROUND

Our interest in studying the multiple family group came from two quite different practically-oriented studies of family life. The first was a study of the role of the family in the maintenance of chronic alcoholism in one of its members. The second study was of an objective, laboratory system for classifying families; the study assessed the power of the classification system to predict how families would participate in a family-oriented, in-patient psychiatric treatment program for adolescents. In the remainder of this section we will briefly describe the alcoholism and hospital studies in order to clarify the reasons for selecting the multiple family group as a method of measurement. In the following section we will briefly sketch a set of orienting theoretical notions about the multiple family group as a small society or community. These notions will help to understand the measures we use in the multiple family group and how we intend to draw inferences from them. All work on this project, theory construction and data analysis, is in mid-phase; it is being presented to the workshop for critical feedback now before we reach closure on several important data analysis decisions now and design decisions for new studies about to begin.

The maintenance of alcoholism. Until recently, alcoholic behavior has been viewed as impulsive and destructive to the alcoholic as well as his relationships with his family. The aim of most treatment programs was to achieve a quick and definite end to the behavior; some treatment programs might then go on to treat underlying personality or social system disorders whereas others might end with the cessation of the alcoholic behavior. More recently, several research groups, taking a less dogmatic stand on the negative consequences of alcoholic behavior, have allowed alcoholic patients to drink during treatment and research programs.[1] This has permitted a more direct assessment of the correlates of alcoholic behavior and of its consequences for the individual and his family. In a series of clinical studies, it was repeatedly observed that some of the consequences of alcoholic behavior could be construed as positive.[2] This seemed particularly true for its effect on family relationships. Indeed, several carefully drawn case studies strongly suggested that alcoholic behavior in one family member would begin after a family crisis had erupted. The alcoholic behavior in the member would induce a series of interactions in the family which, quite suprisingly, helped to solve rather than create a family crisis.

> For example, consider a couple with a young daughter. The wife has been an alcoholic for some time. When she is sober the couple tends to be retiring and timid in its dealings with most non-family members. One evening the young daughter became seriously ill with fever and abdominal pains. The mother called the family doctor but was put off with routine advice about aspirin and rest. The father timidly urged mother to accept his advice. The daughter continued to grow worse; the mother began to drink heavily and she and husband both became more expansive, agressive and bombastic. The doctor was again called. This time a more assertive, if not accusatory, mother got the doctor to see the child in the emergency room. A life-saving operation was performed immediately.

We do not plan to discuss the implications for treatment raised by these clinical findings. More pertinent for this paper is the model elaborated to account for these findings. This model can be summarized as follows. Two types of crises occur in the life of many families. The first type of crisis arises from major dilemmas within the family. Examples include serious disturbances in one of the members (medical or psychiatric) or serious conflicts between two or more members. The second type are crises arising from the family's transactions with its surrounding community. The family of the alcoholic, for reasons we will not go into here, has a well-worn mechanism for dealing with either form of crisis. The alcoholic begins to drink. His social behavior undergoes a rapid change: it becomes less inhibited but also more stereotyped. Comparable changes are induced in interaction patterns in the whole family (not just between each member and the alcoholic but between all dyads of the immediate family). These behaviors have a problem-solving or crisis-resolving effect on family life. In the brief vignette, for example, it was the disinhibition of behavior which had a problem-solving outcome. In other families, the stereotypy and regularity of alcohol-induced family behavior restores a sense of order and cohesion to a family in turmoil. In this sense, stereotyped behavior can also have a problem-solving outcome.

The alcoholism study was designed to test one aspect of this overall model: family interaction--behavior between all members--is less inhibited and more stereotyped when the identified alcoholic is drinking then when he is sober. An important component of this fundamental proposition led to the use of multiple family groups in this study. Preliminary evidence suggested that the two types of crises--internal crises within the family and external crises in the family's transactions with its social world--occurred in different kinds of families. Furthermore, this evidence suggested that families with internal crises would show the predicted shift in behavior--from the sober to alcoholic state--only when behaving in relative privacy whereas families with external crises would show the predicted shift only in public settings. Thus, the study was designed to observe family behavior on a regular basis over 24 weeks in two settings: each family's home and in a multiple family group.

Prospective validation of a family classification system. There are few systematic and comprehensive systems for classifying families based on significant and stable differences between one family and another. The number of such systems is reduced even further if we discount family classification schemes based on the psychopathology of one of its members (e.g. "schizophrenic families" vs. "delinquent families") or on the social subsystem from which the family is sampled ("middle class vs."working class"). Our laboratory has been the first to report a classification system based entirely on objective laboratory tests of the functional capacities of family groups and have reported elsewhere evidence for the concurrent[3] and predictive[4] validity of this system and of the problem-solving methods used to assess and classify families. The study for which multiple family groups were used was a more comprehensive test of the predictive validity of the classification system. Specifically, using the system, we sought to predict how families would integrate themselves into a family-oriented in-patient treatment program for adolescents.

Sophisticated and effective treatment programs of this kind are very often group oriented and directed specifically at the family unit. The adolescent's problem is seen as arising, in whole or in part, from a dysfunctional family. The inpatient treatment service is specifically designed as a "healing community" (Almond).[5] Although only the adolescent is actually hospitalized,

the entire family is engaged--sometimes on a daily basis--in a variety of ward programs. There are two objectives in these porgrams: the first is to help the family resolve serious overt and covert internal conflict in order to work more cooperatively on major psychosocial tasks; the second treatment objective is to teach the family greater skills in its transactions with non-family members. Thus, programs of this kind assist families in their dealing with authority and power issues, as personified in their dealings with staff, and with issues of emotional communication, open relationships and productive cooperation by encouraging relationships with other families of patients on the ward.

The present classification system was systematically derived from a theory of shared constructs in families (parts of this theory have been presented previously at 1973 and 1974 Workshops and in several publications).[6] The basic notion is that every family has its own shared construction or conception of its social world. Although the specific content of these shared constructions may change over time, the fundamental structure and quality of the constructions is quite stable and serves as a continuing influence on how the family understands and deals with any social community. For example, some families typically view their social world with mistrust. People and events are unpredictable, order and system is undiscoverable, events are unmasterable and danger lurks everywhere. By contrast, other families typically view their social world with greater optimism. They usually sense a benign and discoverable order; they collaboratively develop an understanding of people and events and take a more confident view of a world they feel that they can master.

We have proposed that these shared constructions become particularly evident in problem-solving situations. If a family is challenged by any of a broad range of delimited and difficult problems, its basic attitudes and views about social realities will be clearly revealed in their approach to and style of problem-solving.

> For example, a family came to our laboratory to work on a series of pattern recognition tasks. They rushed through the puzzles trying to reach a solution as quickly as possible no matter how much evidence they had to neglect in so doing. The most impressive feature of their performance was the extraordinary demands for consensus, on even the smallest detail of performance, which they exacted from one another. We interviewed the family at the conclusion of their work. They were guarded and apprehensive and tried to conceal their anxiety with a cavalier banter which was painfully out of place. They expressed doubts about the solubility of the puzzle and recalled a single instance where one of the sons had deviated slightly from the rest of the family in his approach to one of the tasks. At recalling this, the mother rose from her chair in fury and hit her son hard on the arm shrieking "you traitor." It became clear that this family perceived the laboratory as dangerous and set themselves the fundamental task of sticking together and getting out as soon as possible. Thus, the family's problem-solving style--haste, premature closure and consensus--clearly reflected their shared perception of the social realities of the laboratory.

The classification grouped families according to their problem solving style and, presumably, the underlying shared views of social reality which they reflected. Based on its classification, we predicted the kinds of perception a family might have of the social realities of the ward community in a psychiatric hospital. This, in turn, led to a prediction of how each class of families would interact within that community. Would they retain rigid boundaries and remain preoccupied with themselves? Would they interact in dependent or hostile ways with staff? Would they understand and engage other

families? The hospital multiple family group, which always included several staff members, was designed as the setting for observing these interactions between family and ward community.

Rationale for the multiple family group. It is clear that we needed to learn, in each study, about the family's transactions with its social community. The multiple family group offered major advantages in comparison to other, more conventional, approaches for studying these transactions. First of all, both studies required direct observation of behavior. Rating schemes, self reports (including questionnaires) and interviews were unlikely to get at the subtle, elusive, intricately patterned phenomena in which we were primarily interested (e.g. stereotyped behavior, the quality of family-staff relationships, etc.). Thus, we needed to directly observe the family's behavior in a community-like setting. A second requirement was standardization. Both studies required the precise comparison between families; in addition, the alcohol study required precise comparisons, for different time periods, within the same family. Thus, the public setting in which observations are made should be reasonably standardized and stable over time. This rules out such approaches as, for example, the naturalistic observation of the family's interaction with non-members on the hospital ward. Finally, we needed a community with longevity. The need for direct observations and standardization argued for an artificially created community-like group. However, a complex social arrangement like this is bound to be confusing and up-ending for most families initially. Thus, it seemed important to establish groups with some longevity in order to make more precise discriminations between families. The clinical literature, describing multiple family groups established exclusively for therapeutic purposes, provided encouragement that groups of this kind could be established, maintained for long periods of time and that many aspects of social behavior could be monitored without great difficulty.[7,8]

To date, the alcohol study has completed observations on three groups, each containing six families. The hospital (classification) study has completed observation on two groups in two different hospitals. The alcoholism groups met in each family's home on a rotating basis. Henceforth, we'll call these groups the home groups. Since they were assembled purely for research, and used only research families, the membership was stable (almost all families were members from the beginning to the end of the group). Although research needs led to the formation of the multiple family groups in each hospital, they became incorporated into the ward treatment program, lasted longer and included families not officially in our classification study. The membership, particularly of one of the groups, was constantly changing; families were continuously joining and leaving the group. All hospital study groups met on the ward. Thus, we call them hospital groups. The home groups were not officially therapy groups (although some assumed this cast). A leader was provided to keep discussion going but he tried to stay in the background serving more as a facilitator. The leaders of the hospital groups were more vigorous, confronting and engaged. A brief summary of the groups and their cardinal differences is in Table 1.

Group	Setting	Duration of group	Process of families entering and leaving	Role of staff
HOSPITAL				
Psychiatric Research Institute (1 group)	Hospital day room	55 weeks	Some families present for the life of the group but most enter after it begins or leave before the group terminates.	Moderately active
Riverside Hospital (1 group)	Hospital day room	116 weeks	No families present throughout; they enter and leave throughout the life of the group	Very active
HOME				
(3 groups)	Member families' homes on a rotating basis	24 weeks	With very few exceptions, families are present throughout the life of the group.	Facilitates but relatively inactive

Table 1. The fundamental contrasting features of the groups. The most important differences are between the two hospital groups on the one hand and the three home groups on the other.

A COMMUNITY CONCEPTION OF THE MULTIPLE FAMILY GROUP

The major hypotheses of the alcoholism study, as we have said, required a comparison of alcoholic and sober behavior—for all families—in a "public setting." Likewise, the prospective study of family classification required a comparison between the family's problem-solving style and its behavior in a "social community." The multiple family group was established to serve as the "public setting" and "social community." However, what kind of "public setting" or "community"is the multiple family group? On a superficial level, its membership, form and immediate objectives are like no other natural social grouping. Moreover, when we study "family behavior" in this setting, what is most important and why? In sum, in order to make good use of our multiple family groups we must answer two fundamental questions: First, what natural communities are most like our multiple family groups? In other words, about what natural groups might it be reasonable to draw inferences from our observations of family behavior? A satisfactory answer to this question requires some typology or classification scheme for communities. This would help us specify which types of social community are similar, in significant ways, to our multiple family groups. A second fundamental question is what family behaviors do we observe? How can we translate and draw measures of behavior, such as verbal participation rates and seating positions, into assessments of the family's "social transactions" with the multiple family group viewed as a community? A satisfactory answer to this question requires that we know the important social structures which govern the behavior of all members of the multiple family group. We can then use family behaviors as an index of how the family has engaged, avoided, altered or been overwhelmed by these underlying group structures. In this section we will sketch out a few orienting notions which help answer these questions.

The multiple family group and other communities. The concept of "community" has been used in two very broad and distinct senses. The first implies a quality of relationship as indicated in Toennie's concept of Gemeinshaft[9] or Redfield's notion of the moral order.[10] Here, community refers to an emotional, expressive and experiential solidarity between individuals, a quality of relationship where people are loved, grasped, apprehended and appreciated for what they are as total, living human beings. It is meant to contrast with the concept of Gesellshaft, in Toennie's terms, or Redfield's technical order where human relationships are shaped by the specific, task-oriented and technical values people have for one another. The second use of the concept of community has been to refer to a bounded, delimited and structured organization of people (whatever the quality of the relationships between them). Within this second perspective, the classic study is clearly the Lynds' comprehensive observations of Muncie (Middletown)[11] and followed by a series of studies of villages, towns and small cities in North America and Western Europe.

In considering the multiple family group as a small community, we want to retain, as far as possible, both meanings of the word. We want to examine it both as a setting in which solidarity and friendship develop between members of different families and as a bounded, delimited structured organization of people within families. It is clear, in the latter sense of the concept of community, that a multiple family group has no obvious similarity to the communities studied in the tradition of the Lynds. As Effrat has pointed out -- in a very useful typology of communities and the studies designed to explore them -- villages, towns and small cities serve a great range of emotional and economic needs.[12] Other communities serve a more selected range of needs. In this latter category communities are, in part, defined by their spatial location and spatial boundaries. The most frequent and best examples of communities so defined are studies of neighborhoods.* Neighborhoods are unlike villages or towns, in most cases, because they provide their individual members with only a portion of what they need economically, socially, or both. Sometimes they contain a mix of people: those who merely live there but are engaged socially and occupationally elsewhere; and those whose entire social and economic lives are rooted in the neighborhood. See, for example, Merton's well-known distinction between "locals" and "cosmopolitans."[14] Effrat also points out that there is another class of communities which, like neighborhoods, are not defined by location or territory. This class contains two types of social organizations. The first are voluntary organizations such as civic clubs, fraternal groups, athletic clubs and teams. Church and labor unions are often not included in this group because they are not seen as truly voluntary.** This is the one area of community studies where,

*An interesting early example, pertinent to our interest in relationship between families, is Mogey's contrast between an established and newly-created neighborhood in Oxford.[13]

**The concept of "voluntariness" is crucial for this class of community-like organizations. Obligatory social organizations, like churches and unions, in some cases, may be viewed as integral components of a higher order, more inclusive community structure. For example, a father in a working class family may -- if he lives in Gary, Indiana -- have to join the steelworker's union in order to get and keep a job. His participation in the union is, then, an example of his transactions with a city considered as a community. Voluntary organizations are seen as somewhat more independent or autonomous; they are, with important exceptions, guided as much by the needs and wishes of their members as by forces from the more inclusive communities (cities and towns) in which they develop. We will return, however, to this concept of the relationship of voluntary organizations to other organizations below.

to our knowledge, the family's role has received little interest. The second sub-section of this class of communities is personal friendship networks or "personal communities," to use Henry's term.[15] The concept, first introduced by Radcliffe-Brown, was applied to families in Bott's classic study.[16] The network is essentially a description, for any individual, of his own friendships and acquaintances with other individuals and, in its complete form, of the relationships between each of those other individuals. The network need not be and, in most cases is not, a face-to-face group of any sort. Membership in a personal network is defined exclusively by the relationship of any individual to the target subject of the study.

From the very brief description we have already given of our multiple family groups, it seems that they are most unlike the more total, complex communities as represented in studies of villages, towns and small cities. However, they are similar in some respects to aspects of the other three. Like neighborhoods, they elicit patterns of relationships among families. Voluntary organizations and personal networks do not directly involve families as the basic unit of membership or interaction. Also like neighborhoods, the hospital groups are, in a limited sense, territorially based. To be sure, the psychiatric hospital, considered as a unitary formal organization, is a component of the complex urban social system; only a few troubled families become engaged with it and then for only brief periods of their lives. Nonetheless, for the time a family is engaged with a psychiatric hospital, it becomes an all-absorbing experience and functions very much as a "small society" (Caudill).[17] In this sense, each ward is a very distinct, territorially bounded community where almost everyone — staff, patients, families — can recognize one another and face-to-face contact is frequent. The hospital multiple family groups, then, may concentrate and highlight the major social processes of this neighborhood-like, territorially based community within the large and impersonal psychiatric hospital. Our groups also are similar to voluntary organizations. This may be particularly true for our home groups, where membership is entirely voluntary; further, the home groups are not defined by or located in a specific space or territory. Finally, it is quite evident that within our multiple family groups clear-cut and specifiable networks of friendship and acquaintances develop and these groups permit an assessment of the development, maintenance, and modification of personal communities. At this stage in our conceptualization of multiple family groups, it seems best to avoid prematurely classifying them as one or another sort of community (or no community at all). Rather, it is best to give some indication of the variety of fundamental social processes which may be observable within them and how these may be related to aspects of everyday community process, and to specific types of studies which have examined those processes. In the section of "first findings" we will return to a more detailed characterization of our groups as communities.

The internal organization of multiple family groups. We adapt three concepts from community studies which are useful for understanding the internal organization of our groups (and thus these concepts will serve as tools for understanding the patterns of behavior we measure). The first is Roland Warren's concept of "verticality."[18] The second concept we have temporarily dubbed "engagement structure." Finally, we examine "stratification" within the group.

Verticality. The concept of "verticality" was introduced into community studies to describe the nature and quality of a community's relationship with non-community social groups and organizations. By contrast, "horizontality" refers to the relationships of various community components with one another. Warren focused on territorially defined communities such as neighborhoods and

small towns; the non-community organizations were inclusive, regionally or nationally based governmental, political, or professionally-oriented groupings. An example is a local welfare office whose policies and practices are entirely controlled by a state welfare department, rather than by transactions within the local community it serves. The concept of verticality, when it is applied strictly to local communities in relation to regional, state and national organizations, is — obviously enough — not applicable to mulitple family groups. Nonetheless, the concept can be generalized to emphasize that our multiple family groups are tied to larger, influential and more inclusive organizations. However, what is most important for our current analyses is that knowledge of these vertical relationships is a useful tool for analyzing the internal organization of our groups. Warren's hypotheses, partially documented from his own findings and those of others, was that strong vertical relationships between a group and outside organizations would weaken the internal or horizontal relationships. This aspect of Warren's concept need not be precisely true for our groups. Nonetheless, strong vertical relationships are clearly manifest in our groups. As we will show, they come out most clearly in the relationship between staff* and families. Staff clearly represent an inclusive institution which stands in an important relationship to the multiple family group: in the home groups of the alcohol study, the staff represent the institution sponsoring the study and in the family classification study, they represent the hospital. We are interested in two aspects of verticality. One is a more quantitative aspect. How much influence or control do outside organizations have on the life of the group? In examining this aspect, it will be useful to assess the three aspects, identified by Etzioni,[19] by which organizations exert influence: <u>normative</u>, the use of symbols and persuasion to change attitudes; <u>remunerative</u>, the use of money and physical rewards; and <u>coercive</u>, the use or threatened use of physical power. A second aspect of verticality which interests us is qualitative. Given a set of externally determined influence and power relationships in the group, as between hospital staff and families, how does the group deal with them? We will be interested in this paper, for example, in contrasting patterns of acceptance versus conflict.

Engagement structure. This concept is meant to embrace two closely related phenomena. The first has to do with the ease or difficulty families face in entering or leaving the groups. Are new families, for example, held at the periphery of group process: not noticed, not talked to, treated with some suspicion perhaps? Does the anticipated departure of a family stir strong feelings and significant recognition or does it go unnoticed? A closely related concept is the notion of a transitional zone in the workings of the group. If a group makes major participatory demands on all its members, then we can say that this zone is small or non-existent. However, groups may permit individuals or families to remain relatively disengaged; a passive or <u>de facto</u> group membership. Lurking or loitering in a transition zone is permitted. It is interesting that groups with this structure may more easily accomodate the research observer whose sole function is to lurk at the group's periphery in order to record interaction and seating patterns. Bell and Newby have noted that the difficulties encountered by the reserach observer in the community may be a good index of the existence of this transitional zone.[20] Some communities will not permit an observer to remain anonymous and hover inconspicuously in an observer's role. Instead, the community will demand engagement, exert control and encourage active participation from

*In the hospital groups, "staff" refers to the psychiatrist group leader and several nurses. In the home groups, staff refers to the group facilitator and the reserach observer.

every person in the life of the community.

If Warren's concepts and observations about the relationship between a community's vertical and horizontal relationships held for our tiny communities, then we might expect that groups with strong vertical relationships might be very open systems indeed. Strong vertical relationships would mean weak horizontal ones of the kind we have just been describing. New families could come, and old families go, virtually unnoticed. A large transition zone would exist, which would easily accommodate research observers and other loiterers and lurkers. However, our first observations of our groups do not support this relationship between verticality and engagement. For the moment, engagement structure ought to be considered a separate aspect of group structure not necessarily related to verticality.

Stratification. We want to apply this concept to our groups to learn whether or not there are stable and dependable hierarchies of status positions into which members are fitted or into which they fit themselves. In accord with several widely-accepted concepts, we regard social status as having two components. The first is an individual's capacity to induce in others a sense of admiration and respect. This is the prestige component. A second component is an individual's capacity to control or disperse the crucial resources of the group; this is the influence aspect of status. The concept of status hierarchy, within groups like ours, includes the notion that there are substantial differences between individuals in both prestige and influence and these influences are correlated, i.e., an individual high on prestige will also be high on influence. Finally, the concept of a stable hierarchy assumes that the dispersion between individuals remains relatively constant and, further, that individuals tend to remain at one particular level for significant durations of time. In rigid hierarchies, they remain fixed and never move; where status mobility is permitted in a group or community, gradual, though definite, shifts do occur. Frequent and extreme shifts by most individuals or families would imply, at least, a relatively weak underlying stratification structure. As we will show in the section on first findings, all of these components of our definition of status hierarchies can be operationalized with some success.

We have two fundamental questions about these hierarchies, once we can establish that they exist. The first concerns the role of families. In our groups are individuals assigned to positions on the basis of family membership? In other words, is an individual who is himself high on a status hierarchy likely to be from a family, all of whose individuals are in a comparable position? In most community studies with which we are familiar, this is the rule. It is families, rather than individuals, who are assigned positions in a status hierarchy. This is due in part (but not entirely) to the fact that attributes which accord a family status in a community — such as the elegance or shabbiness of housing — are attributes that are inseparable from the family as a unit and cannot be attached to one individual. We will return to this issue in a moment.

A second fundamental question about status hierarchies depends on a positive answer to the first question. If we find that individuals are assigned to a position in the hierarchy, or assign themselves, on the basis of family membership, then what is the underlying mechanism for this assignment? There are two possibilities which may operate singly or in concert. The first concerns some skill, attitude, self-image or style of the family itself. In this instance, the family plays an active role in fitting itself into a position in the status hierarchy. For example, a family may be quite effective in alligning itself with staff and conferring upon itself some of the status ordinarily reserved for staff. The other mechanism involves an active placement, by the

group as a whole, of the family into a status position. Where this mechanism operates alone, the family is in a passive position. However, where both mechanisms operate, the multiple family group gives a good opportunity for studying both the synergism and antagonism of group pressures and active family strivings.

If the group does seem to play an active role in establishing a status hierarchy, it would be of great interest to learn the basis or bases for their ratings and assignments. Barber, in a review of a number of community studies, has suggested three possible axes or dimensions by which a community may rate the status of its component families.[21] The first dimension is the family's social class. Barber, as others, emphasizes that this is essentially a community's rating of the prestige of the wage earner's occupation. It is difficult to predict the possible influence of this variable on status rankings in our group. Often occupations of members -- particularly in the large, high turnover hospital groups -- are not learned about quickly, if at all. Peripheral or accessory indicators related to occupation or education may be apparent in dress, manner and speech style but these correlate poorly, at best, with what is meant by occupational status. A second dimension is called family status by Barber. The family as a family can be rated by the group. Several bases for this kind of rating exist. First, the family can be evaluated by how its members deal with one another. In our groups, several criteria of this kind might be developed, on an implicit level. Solidarity and mutual concern is one possibility. Another is firm and effective limit-setting (in home groups this might concern an adult alcoholic; in the hospital groups, the adolescent). The family might also be evaluated for its "external relations" which would include whatever is known about their contributions and eminence in other spheres. In one of our hospital groups, for example, a family of a nationally known entertainer was invariably accorded special status by the group.* A final dimension Barber calls local community status. This refers to the quality of the family's relationship to the community itself. In our groups, an occasional family will be seen by the group as particularly effective in promoting group solidarity; another will be seen as disruptive (often because one of its impulsive members has misbehaved in a way that troubles the group). In community studies, as Barber points out, "old timers" in the community often enjoy special status, particularly if they have a "pioneer" or "founder role." Families in our groups can certainly be distinguished, at any one time, by the amount of time they have been in the community (this is especially true of the high turnover hospital groups). Almond et al have drawn a very clear picture -- in their studies of social processes on psychiatric wards -- of how "old timer" patients become accessory staff members enforcing regulations, advocating staff values and helping, in many ways, to dispense treatment. The data in the current paper is at a stage too rudimentary to document or disentangle these various dimensions of status, although multiple family groups do seem to offer an excellent opportunity to tease these variables apart (our future data analyses will be aimed at precisely this point).

*Barber suggests that the family's heritage may also play a role in its family status. If a family comes from "good stock" or its ancestors were especially prominent -- such as the Roosevelts or Cabots -- the entire current generation may achieve special status to which no other present attribute would otherwise entitle them.

ESTABLISHING, MAINTAINING AND MEASURING MULTIPLE FAMILY GROUPS

Sample.

Families were recruited into our studies in quite different ways. Families in Hospital Group I, located in the Psychiatric Research Institute, had all been referred by private physicians to the adolescent service. Families and individual patients received all treatment free of charge in return for participating in reserach procedures; the multiple family group was described to the families as having both treatment and research objectives. Families often entered Riverside Hospital on referral by a physician; in some cases, they came on their own. They paid a standard fee for services. The multiple family group was presented as a therapeutic opportunity for families. The therapy component was emphasized in a way more forceful than at the Psychiatric Reserach Institute. The research objectives were clearly stated but with less emphasis than in the Psychiatric Research Institute. Families were recruited into the alcohol study by an active public relations effort including advertisements in newspapers and on TV. Each family accepted,had an adult member with a prolonged history of serious alcoholism. However, in many families, the member with the alcoholic history had stopped serious drinking before entering the study or soon thereafter. Each family was paid $350 for participating in 24 multiple family group meetings, one laboratory assessment of interaction and 8 in-home observations. The groups were described, in advance, to each family as an "opportunity to discuss topics of mutual interest." Each family was told in advance that a psychiatrist would be present to act "as a group facilitator." Families in all groups were told that at least one member of the research staff would be present at all meetings to record observations and data.

Table 2 gives some sociographic data on the families in each of our groups. Note that the hospital groups, particularly Group II, were much larger in size and that at least half the families in Home Groups II and III were childless or did not have a child of suitable age for the study (12 or older). The ages of parents as well as social class data is comparable for all five groups. These are clearly upper middle class families. The children in Hospital Group I were somewhat older than the others.

Maintaining and terminating groups. Staff plays a crucial role in keeping the groups going: ensuring good attendance and facilitating the reasonably smooth flow of interaction between families. We will not go into detail here to describe the full range of techniques or interventions they employed. It will suffice to point out that staff plays a particularly important part in initiating the group by establishing a reasonably relaxed and open atmosphere for discussion. Likewise, it plays a crucial role in terminating the group and helping families with feelings about leaving the group. It is equally important to emphasize that the success of each group depends on the investment that most of its member families eventually make in keeping the group going and the discussion on issues that all regard as important. Some families played roles which were clearly accessory to the staff's. Others formed close and significant relationships with one another which, in some groups, persisted after the groups themselves were over.

Measurements. Three measures were used in all five groups; additional procedures, appropriate for the prospective classification study, were used for the hospital groups and additional measurements, appropriate for the

Table 2. Sociographic data on the member families of our five multiple family groups

Group	Total no. of families	No. of families per session $\bar{x}$, S.D.	FAMILY STRUCTURE* 2 par. 1 child	1 par. 1 child	2 adults	other	AGE Parents $\bar{x}$, S.D.	Child $\bar{x}$, S.D.	SOCIAL CLASS** Fa.'s education $\bar{x}$,S.D.	Fa.'s occupation $\bar{x}$, S.D.	social class $\bar{x}$,S.D.
Hospital I	18	8.8,	18	0	0	0	45.9,	16.8,	***	1.9,	***
		1.8					3.7	1.6		.9	
Hospital II	108	15.9,	81	23	0	4	42.5,	14.9	2.5,	2.5,	2.3,
		3.1					5.5	1.2	1.1	1.3	.9
Home I	7	5.4,	6	0	1	0	42.4,	14.4	1.8	2.0,	1.8,
		.7					9.1	1.8 (n=9)	.7	.8	.8
Home II	8	6.1,	4	0	4	0	41.2,	14.2,	1.9,	2.1,	1.9,
		1.1					10.7	2.4 (n=5)	.7	1.1	.7
Home III	7	5.1,	3	0	4	0	45.4,	14.7,	2.2,	2.2,	1.8,
		1.0					10.1	1.7 (n=4)	.9	1.9	1.2

* This was the structure of the family subset which participated in the group. In most cases this was the entire nuclear family. In a few cases very young children were excluded.

* Hollingshead-Redlich scales.

** Data unavailable.

alcohol study, were used for the home groups.

Verbal participation. From the outset of the meeting, the non-participant observer recorded who spoke to whom in precisely the order in which the speech occurred. Staff speech was included in the tally. This verbal interaction was recorded using code numbers for each group member on a computer-compatible recording form. Thus, a variety of indices could be rapidly and automatically computed. The recording of who-to-whom interaction in these very large groups turned out to be surprisingly easy. Because of their size, speakers — in order to be heard or even be noticed — had to be careful to speak clearly and loudly. There was a minimum of overlapping speech, parallel discussion or inaudible asides. All of this made it relatively easy for the observer. Inter-coder reliabilities were invariably high — usually well over .90.

In this paper we use only one verbal participation index, the total amount of speech initiated, i.e. the number of statements made in a session. We use this as a crude though serviceable index of influence in the group. In order to speak, particularly in a very large group, one must successfully gain the attention of others, and insert oneself — at times forcefully — into a stream of discussion. Furthermore, talking frequently occupies a good deal of an important group resource: time. One cannot talk often without, in some way, inducing others to remain silent.

Sociometry. A simple sociometric questionnaire was given to every group member, at the conclusion of the meeting, in all five groups on a regular basis. In the home groups the questionnaire was given at each meeting and asked two questions: which two people in the group would you chose as your representative "to a newly formed community planning committee" and which two would you like "to have join you in forming a newly organized social group." The hospital groups were given sociometric questionnaires monthly with four questions: who in this group "do you most like?" "least like?" "most know?" "least know?" Each member was asked to respond with four names to each question. Quite often they provided fewer than four, particularly to the "least like" question. All group members could choose members of their own family, members or other families or staff.

Seating. The observer also recorded the seating positions taken by each member at the start of the meeting. These were recorded on special computer-compatible projection forms. From these records, computer analysis could reproduce plots which were almost photographic records of the actual seating positions. Inter-rater reliability was again very high, usually well above .90. This rich source of data is not reported in the present paper but we have reported preliminary data on seating patterns elsewhere.[22]

Other measures. The alcohol study coded the presence or absence of themes relating to alcohol in the group discussions and analyzed blood levels of alcohol, using a breathalyzer, before the meeting. The classification study used additional questionnaires and an objective assessment of each family's capacity to observe and understand interaction phenomena in other families in the group. This last is called the Family Perception Procedure. No data from these other measures will be reported in the current paper.

FIRST FINDINGS

This section is divided into two parts. The first gives brief, descriptive vignettes of our five groups. These descriptions give some indication of the great diversity of feeling, process and theme in our groups. Given this diversity, it is all the more surprising that certain underlying patterns seem to be emerging from all five groups. A few of these patterns are illustrated in the very preliminary findings reported in the second part of this section. The vignettes begin to provide an opportunity for exploring the usefulness of the concepts of group structure we have derived from community studies; in particular, the importance of the concept of verticality seems well illustrated. The preliminary quantitative findings explore the concepts of engagement structure, and stratification.

The Quality of Group Experience: Descriptive Vignettes.

Hospital Group I (Psychiatric Research Institute)

"Ethereal Cereal for the Masses"

The salient characteristics of this group were formality, stability, predictability, a unified elite staff group, and a focus on the "here and now" process at the group level. The weekly, seventy-five minute meetings were started and ended by the arrival and departure of a regular, small group of staff, which met among itself prior to and following each meeting. A pattern of concentric circles of chairs evolved early in the life of the group. Empty seats would be left in the inner circle for the senior male clinicians. Nursing staff, mostly females, tended to sit in the periphery. A research team observer sat in the outer circle. The parents and siblings of the ten to twelve hospitalized adolescents were usually in place by the beginning of the meeting. The inpatient adolescents sometimes came a few moments late and clustered on the periphery of the group in what was felt by members to be a quietly disapproving "peanut gallery." The group was an established obligation of families participating in a long-term adolescent/family treatment program where stays were rarely shorter than six months, and intensive individual and individual family and couples therapy was the rule. The attendance of staff and family members was highly consistent and predictable. The focus of meetings tended to differ for staff and family members. Parents were most active, and tended to focus on seeking guidance or understanding of problems they were facing with their adolescents. Staff was focused on the general behavior of the group and tended to interpret individual and group phenomena from a total group perspective. This orientation of staff, their united front and sometimes imperious tone, and their resistance to being drawn into directive interactions with family members, often generated frustration in family members. Nevertheless, overt criticism of the program was rare, even when approximately seven months prior to the termination of the group, it was announced that the research program would be terminating. This event focused both patients and staff on issues of

termination and accommodation with the overall program changes and led to a more shared focus of meetings. For family members, the behavior of staff often seemed inscrutable, distant and frustrating. In other treatment settings with the same staff, however, excellent rapport and good working alliances were the rule.

Hospital Group II (Riverside Hospital)

"A Raucous Town Meeting"

The salient characteristics of this group were informality, continuous and unpredictable changeability, a staff group with less cohesiveness, and a focus on the group as a means for producing social change. The fifty-minute weekly sessions were begun once a quorum of family members and staff had arrived. The primary staff participants were the unit psychiatrist and his two social workers. Participation by other staff was inconsistent, and junior members of staff avoided the meeting in that they were frequently criticized by parents. Up to twenty families were represented in the meeting. The inpatient adolescents, their parents and a smattering of siblings were in attendance. A regular arrangement of seats or seating positions was unusual, with members tending to straggle into the group late from dinner. The inpatient adolescents were active in the meeting, often beginning the meeting by provoking their parents or staff. A research observer sat in the meeting, and twice a month the meeting ended a few minutes early so that research forms could be filled out by the participants. The focus of the meeting was a review of recent events on the unit; consequently the mood of the meeting tended to parallel events and feelings and to be quite variable from week to week. The impact of events on passes and privileges was a frequent topic in that the unit operated with a group responsibility system in which the misbehavior or a few could affect the entire group. The arrival of new families and the departure of old ones was noted. Length of stay varied from a few weeks to perhaps half a year. The "town meeting" flavor of the meeting was encouraged by staff who saw the group as an opportunity for family members to reconstitute a sense of effectiveness and competence. Organization of joint parent, staff, inpatient committees and the planning for sports nights and picnics were encouraged, and at times this activity occupied the meeting. The meeting was also used on occasion as a forum for discussion of hospital or school policy with administrative or teaching staff, a la P.T.A. The function of the meeting and its value was often explicitly brought into question, in that the unit program already involved families and parents with one another in small groups for purposes of therapy. Some families found the meeting a source of support, particularly from members of other families of similar role. Other families found themselves scapegoated or ostracized by the group, particularly when their inpatient adolescent was quite deviant or provocative to the peer group. Relations with staff tended to parallel those in other settings of contact. The unpredictable and rapid changes in group composition and focus seemed to work against a strong sense of group identity or cohesion.

Home Group I

"A Decorous Dozen and Their Children"

Of the three home groups the families in this group were most like each other. They lived, with a single exception, in large single family homes and reported significant involvement with their communities (school and church activities, particularly). They were establishment people outwardly well-integrated into their neighborhoods. The main demographic characteristic differentiating this group was the number of children attending the meetings; almost twice as many as attended either of the other home groups.

The facilitator's style could be best described as Bion psychoanalytic, with definite attempts to introduce transference issues. The group gave him some grief around this issue, but a direct confrontation was avoided because of the presence in the group of an experienced clinical psychologist who was himself a senior group therapist. He moved into a co-therapy role in an unchallenging way and helped shape the direction of the group (his family was consistently chosen most frequently on the sociometric questionnaire). The second major distinguishing feature was the ratio of active to non-active alcoholics in the group. At the start of the group only one family was actively drinking (drinking associated with a lot of physical abuse). Perhaps due in large part to pressure and support from the group, the non-alcoholic wife took a strong stand vis-a-vis her husband the week following a particularly violent episode that necessitated her visiting an emergency room. As a result of this stand the couple decided to separate, and because of the separation were no longer appropriate for the study. Since she was already in therapy with a private psychiatrist, that family left the group.

The major characteristics of the group are as follows: it was a very polite group; aggression when expressed was done so subtley; there were high participation rates for children in comparison to other groups and significantly greater interest by the adults in the opinions, ideas, and activities of the children; relaxed and friendly. In general, it felt more like a group of individuals than a group of families. Boundaries shifted constantly with sub-groups forming and dissolving, depending upon the issue in question. These boundaries seemed permeable and were located to include both parents and children from different families in the same sub-group.

The issue of the treatment of children was the most striking feature of the group. In contrast to other groups, there might be real curiosity expressed by a parent in family A about a child in family B. An even more meaningful process involved a parent in family A reaching out and supporting a child of family B. This kind of evidence supports the notion of permeable boundaries from family to family as evidenced by adult-child interactions.

Alcohol as a theme was dominant over the first six to eight meetings, but then decreased dramatically as "family issues" began to dominate the content of the discussion.

Home Group II

"A Hostile Pack of Factions"

This group was quite different in composition from Home Group I in that half the group were childless couples. The group facilitator took a stance closer to that of a consultant rather than a therapist in the beginning phases of the group. The group tended to treat the facilitator as if he was a parent; this was a reaction similar, in many respects, to transference reactions individual patients develop toward their therapists. For example, the group became furious at the facilitator on the arrival of a new family. They held him fully responsible for permitting an unconscionable intrusion.

The group was by and large dominated by two issues: an ongoing argument between active drinkers and recovered alcoholics ostensibly centering around AA philosophy — good or bad; and second, a split between younger and older subgroups, the younger subgroup being more active and aggressive; the older subgroup being quieter, tending to observe meetings more than participate in them, etc. Children were categorically ignored and tended to be quiet non-participants at meetings. In contrast to Home Group I, there was little interaction between an adult from one family and a child from another.

Since 50% of the families in this group contained an active drinker, it was not surprising that discussion of alcohol dominated the life of the group. Nonetheless, as termination of the group approached, there was a striking shift in the tenor of the group. Alcohol was dropped as an explicit topic and people began to share feelings about separation, self-esteem and death. The last few meetings were particularly trying and attendance was unusually poor at the last meeting. As if to shore itself up, the group planned a barbecue to follow its last official meeting.

Home Group III

"A Troubled Group with Crisis"

The facilitator adopted a stance quite similar to that taken by the facilitator in Home Group II. This was a distressing and disturbing group for the staff. Families, with a single exception, were perceived by the staff as severely disturbed and pathological in their communication. Meetings were therefore uncomfortable for observers. Only four children were present at the group and they rarely participated; they were virtually forgotten by the group, especially insofar as many adult individuals had pressing problems they wanted to present to the group. Families stood out sharply in relief within the group, rarely loosing their sharp distinctiveness vis-a-vis each other and manifesting their

character as families consistently within the group. Therefore a group level flavor and identity was never clearly established, especially insofar as it might have grown out of individuals rather than families within the group.

Families seemed to have little social and emotional resources and were bombarded by a series of reality crises that actually occurred during the course of the study. Crises included deaths of family members (spouse's parents) and close family friends; physical illnesses requiring hospitalization; hospitalizations for detoxification. A depressed and defeated atmosphere prevaded the group, but this was not necessarily precipitated by the reality crises that were occurring. Rather, these crises amplified an underlying depression manifested independently by virtually every family in the group.

As regards alcoholism, the group was evenly split between wet and dry families, but individual drinking histories were far more chronic than in other groups. The length of chronic drinking history and stability of alcoholism in the face of therapeutic intervention contributed as well to the depressed atmosphere in the group.

Group themes were strikingly narrow in scope. There was little sense of community involvement on the part of each family, and alcoholism seem to dominate from start to finish.

Among many issues raised by these vignettes, two seem most important for our present analyses. The first is the differences between the two groups with respect to cohesion (Gemeinschaft). The second issue is verticality, the relationship of the groups with outside and more inclusive groups, and how it influences the inner workings of each group.

Cohesion. We had hoped that our groups would offer an opportunity to observe how families established "community" in Toennies' sense of the term: a sense of solidarity and personal investment in one another. The vignettes convey that three of the groups achieved something of this quality all through at different stages in their development. Home Group I, "the decorous dozen," seemed the earliest to achieve group solidarity with an open acknowledgement from members of the importance of each other as individuals. Hospital Group I, "ethereal cereal," and Home Group II, "pack of factions," achieved an explicit sense of solidarity only late in their development when facing termination of the group and separation from one another. It is these same two groups which has the clearest within-group splits during most of their course. In Hospital Group I, the split was three way: between parents, adolescents and staff. Parents were put off and frustrated by staff's "ethereal cereal," the adolescents postured a carping, non-involvement with both staff and patients and parents were continually annoyed by the adolescents' distancing and taunting. In Home Group II, the most decisive split was between the AA adherents and other families. However, there must have been a covert bond developing between members of both these groups because it clearly emerged with great force as termination approached. It may be that forming factions was a group-level process

for dealing with and concealing the strong feelings--positive and negative--members were developing for one another on a personal basis. The faction formation may have been forstalled in Home Group I by the quick alliance between the family of the clinical psychologist and the facilitator. This bridging function may have helped the group express its solidarity at a much earlier phase.

Many factors may have been responsible for lack of strong solidarity in the other two groups, Hospital Group II and Home Group III. In the former, high rates of turnover--as in unstable neighborhoods--may have been a fundamental block. In Home Group III, families seemed pessimistic about the potential value of any meaningful investments in one another and remained preoccupied with their own dilemmas and crises.

Verticality. In addition to varieties of cohesion, the groups also show differences in verticality. There is, of course, a major difference between the hospital and home groups. The hospital groups are located within a formal organization that exerts great influence on the lives of all group members. This is particularly true of Hospital Group I; the Psychiatric Research Institute could withdraw treatment at anytime a family failed to participate in a research procedure. The power of Riverside Hospital may have been no less great, although more subtle. Once the family made the decision to admit its adolescent, the hospital--through the decisions of its staff--exerted enormous influence. The influence was exerted around practical issues like permission for temporary departures by the patient and his permanent discharge and around more ideological ("normative" in Etzioni's terminology) issues related to therapy, family process and human relationships.

The power of both institutions is represented or symbolized by the staff during the group meetings. It is clear that the groups differed in how family--staff relationship were negotiated. In Hospital Group I, the staff was careful to present a united front and to keep the focus of the meeting very narrow: an examination of the group process itself. In response to this, the families became resistant and complaining; the parents and adolescents expressed this resistance in different ways. The Riverside Hospital staff, on the other hand, did not exert the power they had available in a systematic and united way. Indeed, several staff members broke ranks and did not show up for the meetings and others were willing or even encouraging in letting the group meetings become, political actions. As the vignette describes, the meetings often were directed at producing changes in hospital routine. Thus, although the overall power relationship between group and hospital may have been the same in both hospital groups, Hospital Group II had a more egalitarian quality: staff and families were on more equal footing each negotiating and compromising with the other.

Among the home groups, Home Group II is the most interesting with respect to verticality. Alcoholics Anonymous was a constant "presence" at almost every meeting. Its normative or ideological influence on some of the members clearly expressed itself and provided an impetus for splitting within the group. We have suggested that groups may exploit these vertical relationships in order to avoid the uncertainties and anxieties associated with direct expression of feelings for one another. Nonetheless, the interesting variant--in Home Group II--of an ideologically-based vertical relationship is worth noting.

Preliminary Quantitative Analysis.

We report in this section the first results of quantitative analysis of our multiple family groups. It is important to emphasize that these analyses are still in progress. We report only those findings currently completed in order to suggest analytic approaches to our data and provide a preliminary indication of the kinds of phenomena we are discovering. More complete analyses of our data will almost certainly reshape our views on some important issues.

In this paper we have only qualitative and descriptive data which bears on the first aspect of group structure in which we have an interest, verticality. We have summarized this briefly in the previous section. We plan to do a detailed quantitative analysis of the interaction between staff and families in all five groups as well as an analysis of interaction between the AA and non-AA faction in Home Group II ("Pack of Factions"). These are incomplete and not reported here. We do, however, have some preliminary quantitative data on the second aspect of group structure, engagement.

Engagement Structure. As specified in the first section, engagement structure refers to two separate but closely related phenomena. The first is the ease or difficulty with which new families enter or leave the group. The second is the demands which the group places on each component family for maximum involvement; does the group appear to require families to make a maximum commitment to the group or are graded levels of participation acceptable? One simple, although crude, index of these kinds of participation norms is attendance. Data for four of our groups is shown in Table 3. Here we have tabulated the percentage of sessions attended by each family in each group. We have excluded those families who attended fewer than 10 sessions. For the most part these excluded families never seemed to have developed any genuine contract with the group to participate at all. Most of them dropped out after only a few sessions or, in the case of the hospital group, the adolescent was discharged before the group really got going. For the remaining families we have shown two different distributions. The first is a distribution for the percentage of meetings attended by any member of the family.* The second distribution shows the percent attendance by the entire family.** It is clear that for all four groups the distributions for whole-family attendance are lower and have a greater spread than those for partial-family attendance. This suggests that for all four groups there is a reasonably strong requirement to have at least one member of the family attend but the pressure is less and more variable when it comes to the whole family. It is clear that in

*Since the hospitalized child invariably attended the Hospital Group meetings, a better indicator, for this group, of the attendance of "any family member" is the attendance rate of 1 or 2 parents. Indeed, in the home groups if anyone member attended it was likely to be a parent.

**"Entire family" refers to those members of the family who originally agreed to participate in the treatment program or research project; in almost all cases this was the entire nuclear family although, in some instances, a child was not inclu

Table 3. Attendance in four of the groups by families attending at least 10 sessions.

Hospital Group I-"Ethereal Cereal"

% of meetings attended	1 or 2 parents* no.	%	2 parents no	%
<50			1	10
51-60			1	10
61-70				
71-80	1	10		
81-90			5	50
91-100	9	90	3	30
exactly 100	7	70	0	0
$\bar{x}$	96.3		78.9	
S.D.	9.1		20.0	

*child (patient) attended almost every meeting

Home Group I - "Decorous Dozen"

	Any member*		Entire family	
<50			1	17
51-60				
61-70	1	17	3	50
71-80			1	17
81-90			1	17
91-100	5	83		
exactly 100	1	17		
$\bar{x}$	93.2		67.1	
S.D.	5.8		10.8	

*almost always at least one parent

(continued on following page)

Table 3 (continuation)

Home Group II - "Pack of Factions"

% of meetings attended	Any member no.	%	Entire family no.	%
<50			1	14
51-60			1	14
61-70			1	14
71-80	1	14	2	28
81-90	2	28		
91-100	4	57	2	28
exactly 100	1	14		
$\bar{x}$	89.4		69.9	
S.D.	9.9		21.1	

Home Group III - "Troubled Group"

	Any member		Entire family	
<50				
51-60				
61-70			2	33
71-80	1	17	2	33
81-90	2	33		
91-100	3	50	2	33
exactly 100	1	17		
$\bar{x}$	89.3		71.2	
S.D.	8.8		15.7	

many instances one or more members is representing the whole family.

However, there are some interesting differences between groups. These are summarized in Table 4. This shows that the Hospital group had significantly more families who attended, as incomplete families, 100%* of the meetings. Likewise,attendance as complete families — using 80% of total meetings as an arbitrary cut-off point — was also much more frequent in this group. This difference may simply be a reflection, in behavior, of the difference in the vertical relationships between the two groups. The Psychiatric Research Institute required family attendance at group meetings and other functions and had the power (withdrawal of treatment) to back it up. The more frequent attendance in this group, according to this explanation, is a behavioral indicator that the attendance policy was clearly communicated by the staff and accepted by the families. We know of many psychiatric hospital programs where policies are clear in written manuals but are undercut by inconsistent application by staff and an unchallenged resistance by families. There may be other factors producing the differences between groups as well which will be revealed only through further analyses.

Stratification. In the introductory section we specified that a stable status hierarchy could be recognized by several manifestations. We shall consider each of these in turn.

Prestige and influence components. Of the measures available to us, the most pertinent are verbal participation rates and sociometric choices. For the former we simply measure the number of times an individual speaks in a meeting; in the latter we measure the number of times an individual is chosen by others. For the home groups we combine all the frequencies of being chosen in response to both the community planning and social group questions on the sociometric questionnaire. In the hospital groups we uses only those choices reponding to the questions "Who in this group do you most like?" and "who in this group do you know the best?"**

*The cut-off points of 100% and 80% used here are arbitrary though seem intuitively reasonable.

**In all the analyses to follow we use a descriptive statistic called the "rank percentile". This statistic helps correct for wide fluctuations in mean behavior rates from session to session. For example, some group sessions are very noisy with everyone talking more than usual, whereas some others are very quiet with hardly anyone talking. Since different individuals (and families) are present for different sessions, raw verbal participation rates would be confounded by the noisiness or quietness of the session attended by any particular individual. This distortion could be corrected simply by ranking individual scores vis-a-vis each other. However, the absolute value of rank fluctuates with the number of people present at any session. Thus we divided the rank by the number of people present to produce a rank percentile. If we are scoring fathers, we rank them with respect to all other fathers in the group and divide by the number of fathers present to produce a "father rank percentile." Ranking

(footnote continued)

Table 4. Attendance patterns, contrasts between Hospital I and Home Groups

Attendance by any member

% of meetings attended	Home Groups	Hospital I Group	
less than 100%	16	4	
100%	3	7	$X^2 = 7.13$ $p < .01$

Attendance by all members

less than 80%	14	4	
equal to or greater than 80%	5	7	$X^2 = 4.02$ $p < .05$

Table 5 shows correlations of across-session family means for sociometry and verbal participation. For several of the groups this correlation is significant and for two it is extremely high. This suggests that families who talk alot are also well known, admired or both by other families. Further, most groups show a substantial dispersion of family means along both the sociometry and verbal participation dimensions. These two findings, a correlation of prestige and influence measures and the dispersion does suggest a status hierarchy is developed between familes or individuals or both.

Table 6 examines the stability of these hierarchies. It shows the use of Kendall's coefficient of concordance to measure the stability of the family's and individual's relationship to one another. If high ranking families (or individuals) remain high throughout a block of sessions, mid-zone families remain in the mid zone, and low families remain low, then the coefficient will be quite high (approaching 1.000). If families (or individuals) make major shifts in position, relative to one another, from session to session, then the coefficient will approach 0.00. The coefficient can only be calculated for those families or individuals present at every session for the block. Thus, in the hospital groups we divided the sessions into blocks in a way that maximized both the number of sessions and the number of families present throughout the block. In the home groups we picked the longest single block of sessions in which a minimum of 6 families were present throughout.* Table 6 shows that the coefficients were quite high for all groups for most sessions for both sociometry and verbal participation. In general, there is a slight tendency, particularly in Hospital Group II ("Raucous Town Meeting") for the coefficient to be higher for the latter.

Table 7 carries this analysis forward for Hospital Group I (these analyses are still in progress for the other four groups). Table 6 indicates the status hierarchy was relatively stable in all our groups for

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(continuation of footnote) individuals with other comparable role players (e.g. fathers with fathers, children with children, etc.) helps correct for any tendency for role, by itself, to influence scores. For example, we know that in the home groups children talk much less than adults. "Family rank percentiles" are computed by obtaining a mean of the raw scores for all individuals present at a session, ranking that score in comparison to the means of all other families at that session, and dividing by the number of families. Finally, we are interested in aggregating rank percentiles across sessions — for individuals and families. This is done, in almost all cases, by computing a mean of the rank percentiles computed for each session in which the individual or family was present. The family mean is weighted, in the usual way, for the number of family members present at each session. Thus, a score from a session where four members were present contributes twice as much to the overall, across-session mean as does a score from a session where only two members were present.

*Even these maneuvers did not work perfectly. In some blocks some families did not attend. To eliminate these families would have excessively reduced the sample size for that block. Thus we interpolated data for up to two sessions using the family's overall mean for that block as our best estimate for interpolation. This device probably spuriously increased our coefficients in those occasional instances where it was used.

Table 5. Correlations between being chosen on sociometry and verbal participation, family mean rank percentiles

Hospital Group I "Ethereal cereal" (n=10*)		
"most like" x verb. partic.	.31,	p=ns
"most know" x verb. partic.	.35,	p=ns
"most like" x "most know"	.76,	p<.02
Hospital Group II "Raucous town meeting" (n=33**)		
"most like" x verb. partic.	.32,	p<.05
"most know" x verb. partic.	.32,	p<.05
"most know" x "most like"	.68,	p<.001
Home Group I "Decorous dozen" (n=6)		
sociom. choice x verb. partic.	.82,	p<.05
Home Group II "Pack of fractions" (n=7)		
sociom. choice x verb. partic.	.96,	p<.01
Home Group III "Troubled group" (n=6)		
sociom. choice x verb. partic.	.43,	p=ns

* 8 families left group before sociometry was started.

** This is the subsample of Hospital Group II which participated in the family classification study and for whom we have sociometry data.

Table 6. Stratification as indicated by assessment of consistency of verbal participation and being chosen in sociometry.

Hospital Groups

Hospital Group I - "Ethereal Cereal"

VERBAL PARTICIPATION

Block no.	No. of families	No. of sessions	FAMILY		PARENTS		CHILDREN	
			W	$p <$	W	$p <$	W	$p <$
1	7	9	.36	.01	.72	.001	.21	.01
2	8	13	.57	.001	.46	.001	.40	.001
3	10	11	.62	.001	.64	.001	.53	.001
4	7	15	.63	.001	.64	.001	.52	.001

SOCIOMETRY

Block no.	No. of families	No. of sessions	Most know family		Most like family	
			W	$p <$	W	$p <$
1	9	4	.639	.01	.493	.05
2	7	4	.637	.01	.588	.02

(continued on following page)

Table 6 (continuation)

Hospital Group II - "Raucous Town Meeting"

VERBAL PARTICIPATION

Block no.	No. of families	No. of sessions	FAMILY		PARENTS		CHILDREN	
			W	$p <$	W	$p <$	W	$p <$
1	7	8	.48	.001	.32	.05	.63	.001
2	5	8	.37	.02	.42	.01	.50	.01
3	8	10	.66	.001	.44	.001	.69	.001
4	8	8	.73	.001	.65	.01	.47	.001
5	9	7	.61	.001	.45	.20	.50	.001
6	8	7	.47	.01	.23	.01	.50	.01
7	6	8	.58	.001	.49	.01	.41	.01
8	7	7	.72	.001	.46	.001	.65	.001
9	7	7	.65	.001	.59	.05	.49	.01
10	10	6	.41	.01	.33	.05	.63	.001
11	7	6	.19	ns.	.35	.05	.41	.05
12	4	5	.33	ns.	.52	.05	.46	.10
13	4	5	.50	.01	.40	.05	.57	.01

SOCIOMETRY

Block no.	No. of families	No. of sessions	Most know family		Most like family	
			W	$p <$	W	$p <$
1	9	3	.63	.05	.84	.01
2	14	3	.71	.01	.60	.02
3	10	3	.59	.10	.61	.05
4	6	3	.44	ns.	.64	.10
5	8	3	.49	ns.	.58	.10
6	11	3	.53	ns.	.65	.05
7	7	3	.23	ns.	.43	ns.

(continued on following page)

Table 6 (continuation)

Home Groups

Home Group I - "Decorous Dozen"

Block no.	No. of families	No. of sessions		FAMILY W	FAMILY p≤	PARENT W	PARENT p≤	HUSBAND W	HUSBAND p≤	WIFE W	WIFE p≤
			VERBAL PARTICIPATION								
1	6	12 (sess 11-12)		.13	ns.	.27	.01	.88	.01	.02	ns.
			SOCIOMETRY								
				.67	.01	.73	.01	.78	.01	.62	.01

Home Group II - "Pack of Factions"

			VERBAL PARTICIPATION								
1	7	12 (sess 8-19)		.77	.01	.46	.01	.30	.01	.59	.01
			SOCIOMETRY								
				.49	.01	.36	.01	.19	.10	.39	.01

Home Group III - "Troubled Group"

			VERBAL PARTICIPATION								
1	6	12 (sess 8-19)		.27	.01	.59	.01	.59	.01	.47	.01
			SOCIOMETRY								
				.53	.01	.18	.10	.25	.05	.52	.01

blocks of 5 to 12 sessions. However, it is possible for a family or individual to slowly drift up or down in this hierarchy; for any one block his position might not change but from the start to the end of his tenure in the group he may have transversed the entire range. The cross-lagged correlations in Table 7 indicated that for verbal participation in Hospital Group I, this is not true. Parents who start out noisy remain noisy and quiet parents stay quiet; the same is true for children. The Table also shows that parents who are noisy with respect to other children (correlation of parent first 10 rank percentile with children first 10 and parental last 10 with children last 10 sessions). Further, these relations are quite stable (parent first 10 predicts children last 10 and vice versa). These correlations not only suggest an extremely stable hierarchy but that it is families -- as a group -- which are positioned in the hierarchy. Noisy parents have noisy children.

We can carry our analysis one step further. We can ask whether the family positions itself in the status hierarchy or is positioned by the group, on the basis of some enduring and stable attribute; this attribute, according to this argument, exists before the family's entry into the group and influences its position throughout its stay. For example, some attribute of social class, or education or "psychological mindedness" might prompt the group to place the family in a particular niche where it remains throughout its tenure in the group. Or, continuing along this line, some feeling the family has about itself (an elitist self-image, perhaps) or its typical reactions to strange social situations (to be very talkative) might predetermine the level into which its fits itself. We are talking here about some sort of "family personality." All these explanations posit a fixed attribute of the family prompting them or others to fit them into a fixed niche. An alternate explanation posits a more active regulation of the family by itself or outside forces in the group. This mechanism, while it can include the role of stable characteristics of the family, concerns small but important variations in participation rates from session to session. We know that in Hospital Group I -- as in all five group -- that families do have variations from session to session (since Kendall's coefficient does not reach 1.000 for any block in any group). If the parent in a "noisy" family becomes somewhat less noisy than in the previous session, will the adolescent follow suit? If a child in a "quiet" family becomes more "noisy" than before, will his or her parents do likewise? This form of within-family imitation or regulation would depend on continuous mutual monitoring by members of a family or between the group and family; it could not be explained by a family norm or "personality" established before the family's entry into the group.

Table 8 shows rank-order correlation coefficients computed for each of 10 families who attended at least 20 sessions. The correlations relate the rank percentiles of the parents and the hospitalized adolescent for each session. A positive, significant correlation -- obtained here for 8 of the 10 families -- suggests that if either a parent or an adolescent changed his or her level of participation in the group, the other would very quickly follow suit. This coordination occurred early in the session, at the latest within a

Table 7. Cross-lagged correlations between the means of first and last 10 sessions for verbal participation in Hospital Group I (n=10°)

	Parents first 10	Parents last 10	Child first 10	Child last 10
Parents first 10	--			
Parents last 10	.89***	--		
Child first 10	.72*	.80**	--	
Child last 10	.69*	.71*	.81**	--

*** $p < .001$ ** $p < .01$ * $p < .05$

°the number of families present for at least 20 sessions

Table 8. Within-family rank-order correlations relating verbal participation levels of parents and adolescents in each of 10 families present for 20 or more sessions.

Family number	Number of sessions	rho	p <
6	46	+.53	.003
8	34	+.36	.04
10	27	+.53	.004
11	40	-.01	n.s.
12	44	+.32	.03
14	44	+.51	.0007
15	40	+.24	.13
16	37	+.33	.05
17	35	+.49	.003
18	23	-.02	n.s.

few minutes. If the imitative adjustments were not made until the end of the session they would not have been reflected in the total participation score for that session.

If stable hierarchies can be confirmed in all our groups, it will then be our task to determine the origin of those hierarchies. Do any of the components of social class (occupational rating, education, etc.) play a role?* Do attributes of the family itself, independent of social class, influence its position in the hierarchy? Finally, does the family's contribution or commitment to the group influence its position? For example, are regular attenders in positions higher than sporadic attenders? Another distinct possibility is that staff play a critical role in determining status of families within the group; attention and support by staff, as indicated -- for example -- in frequent verbal interaction with a favored subset of families, may play a significant role in establishing a status hierarchy.

*The home groups provide an enthralling opportunity for studying the effects of size and elegance of a family's house on his status within the group. Recall that the home groups rotate from house to house so that in the course of any group a family has four opportunities to host a meeting in his house. We have detailed descriptions and measurement of the house of every family in our alcoholism study.

DISCUSSION AND SUMMARY

We have interspersed discussion and speculation at various points in our paper and only a few additional points, in the service of summation, need be raised here.

In this paper we have described our reasons for establishing and studying multiple family groups. We have provided data which indicates that with two populations of families — those of alcoholics and those of very troubled adolescents — establishing, maintaining, and studying multiple family groups is practical and provides useful data. However, the main focus of our paper has been to examine the multiple family group as a small community. We have adapted certain concepts from studies of natural communities of various types and have asked the question, how useful are these concepts for analyzing and understanding the internal structure of our multiple family groups? We will summarize here what we believe the data so far suggests.

The most overall concept of "community" is, as we have pointed out, that of Ferdinand Toennies. His concept, concerning the fundamental bonds of solidarity between individuals, lies at the base of all subdivisions and typologies of communities. Our initial experience, described mainly in the vignettes, suggests that the multiple family group is a useful setting for studying some of the factors which promote or retard the development of community in this broadest sense of the term. Here, we have noted the importance of faction formation, turnover in membership and chronic pessimism about human relationships as factors retarding the development of community.

We also examined three specific aspects of internal structure of our groups. Like the overall concept of community, these aspects were also derived from studies of communities. The first was verticality. While we have no completed quantitative analyses in hand, the descriptive accounts of the multiple family groups seemed to confirm the value of this concept. It revealed, first, that groups differ in the quality of their vertical relationships with extra-group organizations; this much is hardly surprising. More important, our descriptions showed that groups differ among themselves in how they negotiate and structure vertical relationships. A particularly striking contrast was between the two Hospital Groups. The first group showed a distancing elitism between staff and families, the latter a raucous ,though egalitarian,political struggle.

The notion of engagement structure was explored through preliminary analysis of attendance patterns. Further analysis is essential to form even a preliminary judgement about this concept. Nonetheless, even our preliminary data revealed a striking and understandable difference between one of the hospital groups and the three home groups.

We explored the concept of stratification more fully. All groups showed evidence of stratification along prestige and influence lines. In other words, individuals and families were clearly distinguishable from one another in how much respect or esteem they enjoyed and how much influence (as indicated by verbal participation) they could exert. Our data showed that influence and prestige were correlated with one another and, for any family, stable over many sessions. In the one group for whom we have data, the hierarchy of status seems to be maintained, in part, by a very active process. Families are kept together --

by pressures internal or external to them. If one member shifts position slightly, the others will follow suit very quickly.

By way of summary, we may say that social processes fundamental in the life of everyday communities do seem to make their appearance in our artificial multiple groups. This allows us to be reasonably optimistic that the basic needs of our two studies — the alcohol study and the family classification study — will be met. Our need to know how families behave in a community setting, and what that behavior implies about them, may be served well by the multiple family groups.

We may ask though, in conclusion, whether other investigators interested in family-community relationships would profit from studying multiple family groups. In part, this question may be rephrased: are the kinds of families we use in our work radically different — in their behavior in large groups — than those in other kinds of studies? It might be argued that our families are troubled and are quick to flock to any project which offers a hint of help or assistance. To continue this argument, untroubled families, no matter how well paid, could never have been induced to form artificial communities of this kind. Of course, our data — drawn as it is from studies of troubled families — cannot answer this question. We can offer only a speculative response to this concern. First, it is our impression that there is a very broad range of families within our samples. For example, although all families clearly have a troubled member, they are not all "troubled families." Indeed, qualitative and quantitative data emerging from our studies reveals that some of our families are indistinguishable, as families, from a broad range of families who have no alcoholic or psychiatric problems. Second, it is our impression that when group cohesion does form, in our multiple family groups, it does not arise from the needs of troubled families to receive help. Indeed, as our vignettes point out quite graphically, when families talk about their "official difficulty" (alcoholism, for example), group cohesion is blocked. Moreover, the passive wish for help (as in Home Group III, "Troubled Group") from the staff also seems to retard cohesion. We would suggest that true group cohesion, community in the broadest sense, arises from a family's basic need for solidarity with other families. This need, it seems to us, is present in all families. Thus, our groups might have some special characteristics but groups, quite comparable in many respects, might well be formed with families of many types.

BIBLIOGRAPHY

1. Tamerin, J., Mendelson, J.H. The psychodynamics of chronic inebriation: Observations of alcoholics during the process of drinking in an experimental group setting. Amer. J. Psychiat., 125:886-889, 1969.

2. Steinglass, P., et al. A systems approach to alcoholism. A model and its clinical application. Arch. Gen. Psychiat., 24:401-408, 1971.

3. Reiss, D. Varieties of consensual experience III. Contrast between families of normals, delinquents and schizophrenics. J. Nerv. Ment. Dis., 152:73-95, 1971.

4. Reiss, D. Intimacy and problem solving: an automated procedure for testing a theory of consensual experience in families. Arch. Gen. Psychiat., 25:442-455, 1971.

5. Almond, R. The Healing Community, New York, Jason Aronson, 1974.

6. Reiss, D. Varieties of consensual experience I. A theory for relating family interaction to individual thinking. Fam. Process, 10:1-28, 1971

7. Laquer, H.P., Wells, C. and Agresti, M. Multiple family therapy in a state hospital. Hosp. and Community Psychiat., 20:13-20, 1969.

8. Blinder, M., Colman, A., Curry, A. and Kessler, D. MCFT: Simultaneous treatment of several families. Amer. J. Psychother., 19:559-569, 1965.

9. Toennies, F. Community and Society, New York, Harper Torchbook, 1957.

10. Redfield, R. The Primitive World and Its Transformations, New York, Cornell University Press, 1953.

11. Lynd, R.S. and Lynd, H.M. Middletown: A Study in Contemporary American Culture. New York, Harcourt Brace, 1929.

12. Effrat, M. P. Approaches to community:Conflicts and complementarities. Sociol. Inq., 43:1-32, 1973.

13. Mogey, J.M. Family and Neighbourhood, Westport, Greenwood Press, 1974.

14. Merton, R.K., Local and cosmopolitan influentials, in Warren, R.L. (ed.) Perspective on the American Community (2nd edition), Chicago, Rand McNally, 1973.

15. Henry, J. The personal community and its invariant properties, Amer. Anthro., 60:827-831, 1958.

16. Bott, E. Family and Social Network (2nd edition), New York, Free Press, 1971.

17. Caudill, W. The Psychiatric Hospital as a Small Society, Cambridge, Harvard University Press, 1958

18. Warren, R.L. The Community in America (2nd edition), Chicago, Rand McNally, 1972.

19. Etzioni, A. A Comparative Analysis of Complex Organizations, New York, Free Press, 1961.

20. Bell, C. and Newby, H., Community Studies, New York, Praeger, 1973.

21. Barber, B. Family status, local community status and social stratification: Three types of social ranking. Pacific Sociol. Rev., 43:3-10, 1961.

22. Reiss, D. and Costell, R., The multiple family group as a small society: Family regulation of interaction with nonmembers, Amer. J. Psychiat., 134:21-24, 1977.

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